		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038893

Facility Name: Center Home for Hispanic Elderly

Address: 1401 N. California (Number) Chicago (City) 60622 (Zip Code)

County: Cook

Telephone Number: 773-7828700 **Fax #** 773-2760465

IDPA ID Number: 36-3527934001

Date of Initial License for Current Owners: 02/18/82

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Dan Malone **Telephone Number:** 708-3614295

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 6/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Gilberto Torres
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title) Daniel L. Malone
(Firm Name & Address) DLM Financial Advisory Services, 133 S. Old Creek Rd. Palos Park,IL.60464
(Telephone) 708-3614295 Fax # 708-3614295

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3	58	Intermediate (ICF)	58	21,170	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	156	TOTALS	156	56,940	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,977			16,977	8
9	SNF/PED					9
10	ICF	32,844	1,825		34,669	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	49,821	1,825		51,646	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.70%

D. How many bed-hold days during this year were paid by Public Aid?
2,781 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 02/18/82

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: June 30,2002 Fiscal Year: June 30,2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 **Report Period Beginning:** 07/01/01 **Ending:** 6/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	333,292	48,669	9,638	391,599		391,599	221	391,820			1
2	Food Purchase		239,954		239,954		239,954	(19,059)	220,895			2
3	Housekeeping	58,994	43,277		102,271		102,271	8,010	110,281			3
4	Laundry	90,445	25,208		115,653		115,653		115,653			4
5	Heat and Other Utilities			101,020	101,020		101,020	27,926	128,946			5
6	Maintenance	118,647	10,341	34,510	163,498		163,498	12,500	175,998			6
7	Other (specify):*											7
8	**TOTAL General Services**	601,378	367,449	145,168	1,113,995		1,113,995	29,598	1,143,593			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,036,458	175,193	272,943	2,484,594		2,484,594		2,484,594			10
10a	Therapy	38,445			38,445		38,445		38,445			10a
11	Activities	111,150		12,616	123,766		123,766		123,766			11
12	Social Services	94,039		1,333	95,372		95,372		95,372			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,280,092	175,193	286,892	2,742,177		2,742,177		2,742,177			16
	C. General Administration											
17	Administrative	245,261		504,084	749,345		749,345	(464,857)	284,488			17
18	Directors Fees											18
19	Professional Services			67,297	67,297		67,297	15,015	82,312			19
20	Dues, Fees, Subscriptions & Promotions			4,169	4,169		4,169	1,489	5,658			20
21	Clerical & General Office Expenses	179,633	61,987	13,664	255,284		255,284	260,457	515,741			21
22	Employee Benefits & Payroll Taxes			641,949	641,949		641,949	31,586	673,535			22
23	Inservice Training & Education			492	492		492		492			23
24	Travel and Seminar			2,589	2,589		2,589	356	2,945			24
25	Other Admin. Staff Transportation			9,688	9,688		9,688	2,907	12,595			25
26	Insurance-Prop.Liab.Malpractice			49,250	49,250		49,250	5,464	54,714			26
27	Other (specify):*											27
28	**TOTAL General Administration**	424,894	61,987	1,293,182	1,780,063		1,780,063	(147,583)	1,632,480			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,306,364	604,629	1,725,242	5,636,235		5,636,235	(117,985)	5,518,250			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Center Home for Hispanic Elderly #0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			135,169	135,169		135,169	89,140	224,309			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			89,660	89,660		89,660	35,725	125,385			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			63,609	63,609		63,609		63,609			35
36	Other (specify):*											36
37	**TOTAL Ownership**			288,438	288,438		288,438	124,865	413,303			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee	85,410			85,410		85,410		85,410			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	85,410			85,410		85,410		85,410			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,391,774	604,629	2,013,680	6,010,083		6,010,083	6,880	6,016,963			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,532)	Line 32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Senior Lunch	(19,059)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (20,591)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	27,471	Pages 8,8a	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 27,471		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 6,880		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$ N/A		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops		x	N/A		41
42	Laboratory and Radiology		x	N/A		42
43	Prescription Drugs		x	N/A		43
44	Exceptional Care Program		x	N/A		44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 **Report Period Beginning:** 07/01/01 **Ending:** 6/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Center Home for Hispanic Elderly

ID# 0038893

Report Period Beginning: 07/01/01

Ending: 6/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 **Report Period Beginning:** 07/01/01 **Ending:** 6/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Casa Central	Chicago	Not For Profit
				Padres Corporation	Chicago	Not For Profit

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Other Administrative Expense	$ 504,084	Padres Corporation	0.00%	$ 531,555	$ 27,471	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 504,084			$ 531,555	$ * 27,471	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	None	None	None	None	None	None	None	None	$ None	None	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Casa Central Padres Corporation
Street Address: 1343 N. California Ave.
City / State / Zip Code: Chicago, IL. 60622
Phone Number: (773-6452300
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Please Refer	To The Attached Schedules	Total Operating Costs	2	2	$ 1,719,128	$ 1,011,189		$ 0	1
2			For Each Entity							2
3	Various	Salaries and Benefits	Salaries are allocated to Page 3, Line 17 and Line 21. The executive director's salary is reported on line 17 in the amount of 39,226.						308,081	3
4	Line 19	Legal Expense	Fringe benefits of 31,586 were reported on line 22 of page 3. Copies of all the invoices for legal fees have been attached.						2,903	4
5	Line 21	Office Supplies							11,738	5
6	Line 3	Housekeeping Supplies							8,010	6
7	Line 1	Kitchen Supplies							221	7
8	Line 6	Building Repairs and Maintenance							4,448	8
9	Line 6	Building Inspection Fees							197	9
10	Line 26	Property Insurance							5,464	10
11	Line 6	Scavenger Service							2,898	11
12	Line 6	Exterminating Service							239	12
13	Line 6	Elevator Maintenance							1,551	13
14	Line 5	Electricity							24,874	14
15	Line 5	Gas							3,499	15
16	Line 5	Water							(447)	16
17	Line 32	Interest Expense							37,257	17
18	Line 21	Telephone Expense							11,422	18
19	Line 6	Equipment Repairs and Maintenance							3,167	19
20	Line 25	Auto Expense							2,772	20
21	Line 19	Other Professional Fees							1,847	21
22	Line 21	Temporary Help							29	22
23	Line 19	Accounting and Audit Fees							5,279	23
24										24
25	TOTALS					$ 1,719,128	$ 1,011,189		$ 435,449	25

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	Line 19	Computer Services				$	$		$ 4,986	1
2	Line 24	Travel and Seminar							356	2
3	Line 24	Transportation							135	3
4	Line 22	Employee Want Ads							1,489	4
5	Line 30	Depreciation Expense							89,140	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 531,555	25

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Amercan National Bank		x	Building Mortgage			$	$ 298,058			$ 26,143	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Amercan National Bank		x	Working Capital	Interest Only			925,000		Variable	59,573	6
7	Washington Square		x	Working Capital				97,478		Variable	3,944	7
8								Working Capital Interest Expense Is Combined				8
9	TOTAL Facility Related						$	$ 1,320,536			$ 89,660	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 1,320,536			$ 89,660	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Center Home for Hispanic Elderly **#** 0038893 **Report Period Beginning:** 07/01/01 **Ending:** 6/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ Not Applicable	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	Not Applicable	8
	1998	Not Applicable	9
	1999	Not Applicable	10
	2000	Not Applicable	11
	2001	Not Applicable	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Center Home for Hispanic Elderly COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0038893

CONTACT PERSON REGARDING THIS REPORT Grace Torres

TELEPHONE 773-7828700 FAX #: 773-276-465

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	None Not Applicable	None Not Applicable	$ None Not Applicable	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ None Not Applicable	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 59,149 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 4

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	55,145	1981	$ 45,000	1
2					2
3	TOTALS	55,145		$ 45,000	3

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	149		1981		$ 255,000	$ 10,200	25	$ 10,200	$	$ 209,100	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements			1982	2,251	90	25	90		1,845	9
10	Fire Sprinkler, Windows and other items			1983	205,573	8,223	25	8,223		160,346	10
11	Fire Alarms, Wheelchair Ramp & Other Items			1985	41,435	1,657	25	1,657		29,804	11
12	Elevator, Nurse's Station & Rear Stairway			1986	236,110	9,444	25	9,444		155,832	12
13	Door, Carpeting & Air Conditioning Lines			1988	1,153	46	25	46		669	13
14	New Roof & Tuckpointing			1990	38,398	2,560	15	2,560		30,719	14
15	Heating, Fire Alarms & Other Items			1984	72,587	2,904	25	2,904		53,715	15
16	Elevator Repair & Tuckpointing			1992	10,325	688	15	688		6,940	16
17	Elevator Repair & Tuckpointing			1993	67,891	4,527	15	4,527		41,844	17
18	Improvements			1994	44,641	2,976	15	2,976		25,616	18
19	Elevator Repair & Roof Repairs			1995	42,324	2,822	15	2,822		21,898	19
20	Front Door			1995	11,843	789	15	789		6,112	20
21	Electrical Improvments			1995	213,730	14,289	15	14,289		114,029	21
22	Boiler Repairs			1995	15,681	1,045	15	1,045		7,781	22
23	Water Heater			1995	2,025	135	15	135		1,069	23
24	Plumbing Repairs			1995	1,550	103	15	103		792	24
25	Laundry and Kithchen Repairs			1996	10,500	700	15	700		4,786	25
26	4 th Floor Construction			1996	10,300	687	15	687		4,611	26
27	Boiler Repairs			1996	2,180	145	15	145		993	27
28	Electric Upgrade			1996	895	60	15	60		378	28
29	Kitchen Repairs			1997	4,200	280	15	280		1,571	29
30	Elevator Repairs			1997	23,440	1,563	15	1,563		8,630	30
31	Electrical Repairs			1997	6,985	466	15	466		2,603	31
32	Install New Doors			1997	1,675	112	15	112		587	32
33	Boiler Repairs			1997	3,573	238	15	238		1,250	33
34	Rewire Kitchen and Sump Pumps			1991	41,225	2,748	15	2,748		30,233	34
35	Airconditioning Lines			1989	2,696	108	15	108		1,456	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bathroom Remodeling	1998	$ 96,661	$ 6,444	15	$ 6,444	$	$ 28,899	37
38	Elevator Repair	1998	3,000	200	15	200		883	38
39	Laundry Pumps	1998	4,422	294	15	294		1,289	39
40	Electrical Work	1998	31,052	2,070	15	2,070		8,670	40
41	Airconditioner	1998	933	62	15	62		264	41
42	Kitchen Work	1998	3,903	260	15	260		1,062	42
43	Boiler Repairs	1998	1,875	125	15	125		510	43
44	Dampers	1998	6,220	415	15	415		1,694	44
45	Doors and Frames	1998	20,263	1,350	15	1,350		5,567	45
46	Building Improvements: Electrical Transfer Switches	1999	9,591	639	15	639		2,451	46
47	Kitchen Fire Extinguishing System	1999	1,500	100	15	100		383	47
48	Toaster Wiring	1999	1,370	91	15	91		335	48
49	Boiler Repairs	1999	2,977	198	15	198		694	49
50	Baseboard Radiators	1999	1,000	67	15	67		234	50
51	Baseboard Radiators	1999	800	53	15	53		186	51
52	Electrical Transfer Switches	1999	3,500	233	15	233		777	52
53	Access Panels	1999	3,125	208	15	208		694	53
54	Access Panels	1999	1,025	68	15	68		216	54
55	Fire Dampers	1999	1,550	103	15	103		326	55
56	Roof Repairs	1999	1,000	67	15	67		211	56
57	Roof Repairs	1999	1,000	67	15	67		211	57
58	Water Heater	1999	3,490	233	15	233		698	58
59	Electrical Repairs	1999	2,443	162	15	162		488	59
60	Exit Signs	1999	1,089	73	15	73		206	60
61	Water Heaters	1999	1,490	99	15	99		248	61
62	Metal Fencing	1999	1,000	67	15	67		200	62
63	Metal Fencing	1999	800	53	15	53		159	63
64	Replace Handrails	1999	26,000	1,733	15	1,733		4,044	64
65	Upgrade Telephone System	1999	3,772	251	15	251		586	65
66	Boiler And Gasline Replacement and Repairs	1999	3,990	266	15	266		798	66
67	Emergency System Upgrade	1999	3,440	229	15	229		687	67
68	Dairy Compressor and Stairway Lights	2000	7,204	480	15	480		1,325	68
69	Computer Wiring	2000	4,958	330	15	330		1,036	69
70	TOTAL (lines 4 thru 69)		$ 1,626,629	$ 86,695		$ 86,695	$	$ 991,240	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,626,629	$ 86,695		$ 86,695	$	$ 991,240	1
2	Water Heater	2000	6,980	465	15	465		1,124	2
3	Floor Tile	2000	258	6	15	6		92	3
4	Kitchen Rehab	2000	4,286	348	15	348		1,332	4
5	Handrails	2000	13,500	900	15	900		2,025	5
6	Roof Repairs	2000	27,600	1,840	15	1,840		4,140	6
7	Emergency Generator	2000	64,267	4,284	15	4,284		9,282	7
8	Roof Repairs	2000	28,000	1,867	15	1,867		3,890	8
9	Sump Pumps	2001	4,750	264	15	264		528	9
10	Alarm System	2001	2,776	139	15	139		278	10
11	Handrails	2001	12,132	539	15	539		1,078	11
12	Windows	2001	2,300	38	15	38		76	12
13	Water Tank	2001	5,452	182	15	182		364	13
14	Tank Removal	2001	9,510	207	15	207		414	14
15	Windows	2001	3,560	158	15	158		340	15
16	Tuckpointing	2001	900	10	15	10		20	16
17	Handrails and Architectural Fees	2001	5,163	29	15	29		58	17
18	Electrical Wiring	2001	1,153	6	15	6		12	18
19	Disposal Valve	2001	400	2	15	2		4	19
20	Emergency Generator Install Wiring	2001	550	3	15	3		6	20
21	Boiler	2001	4,429	25	15	25		50	21
22	Floor Tile	2001	512	3	15	3		6	22
23	Selector Unit for Building Elevator	2001	5,200	29	15	29		58	23
24	Generator Tank Removal	2001	4,000	111	15	111		222	24
25	Sewage Pump	2001	7,348	247	15	247		494	25
26	Alarm System	2001	4,470	199	15	199		398	26
27	Construction In Progress	1989	8,500		15				27
28	Roof Repairs	2001	1,927	128	15	128		128	28
29	Elevator Repairs	2001	21,440	2,310	15	2,310		2,310	29
30	Boiler Repairs	2001	3,313	166	15	166		166	30
31	Kitchen Plumbing	2001	1,500	58	15	58		58	31
32	Fire Rated Door	2002	1,800	60	15	60		60	32
33	New Boiler	2002	2,002	92	15	92		92	33
34	TOTAL (lines 1 thru 33)		$ 1,886,607	$ 101,410		$ 101,410	$	$ 1,020,345	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,886,607	$ 101,410		$ 101,410	$	$ 1,020,345	1
2	Elevator Repair	2002	10,000	222	15	222		222	2
3	Fire Alarms and Exit Signs	2002	7,208	160	15	160		160	3
4	Electrical Work Laundry	2002	1,839	41	15	41		41	4
5	Building Elevator Repair	2002	1,340	22	15	22		22	5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,906,994	$ 101,855		$ 101,855	$	$ 1,020,766	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 1,906,994	$ 101,855		$ 101,855	$	$ 1,020,766	1
2									2
3	Casa Central Padres Corporation Costs Allocated to Center Home		1,539,593						3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,446,587	$ 101,855		$ 101,855	$	$ 1,020,766	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 282,646	$ 27,206	$ 27,206	$		$ 221,070	71
72	Current Year Purchases	49,049	4,174	4,174			4,174	72
73	Fully Depreciated Assets	72,097					72,097	73
74								74
75	TOTALS	$ 403,792	$ 31,380	$ 31,380	$		$ 297,341	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,895,379	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 133,235	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 133,235	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,318,107	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Center Home for Hispanic Elderly **#** 0038893 **Report Period Beginning:** 07/01/01 **Ending:** 6/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 73,851	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,147,771		3
4	Supply Inventory (priced at)	18,194		4
5	Short-Term Investments			5
6	Prepaid Insurance	143,750		6
7	Other Prepaid Expenses	2,980		7
8	Accounts Receivable (owners or related parties)	687,064		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,073,610	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	45,000		13
14	Buildings, at Historical Cost	255,000		14
15	Leasehold Improvements, at Historical Cost	1,653,292		15
16	Equipment, at Historical Cost	403,793		16
17	Accumulated Depreciation (book methods)	(1,318,107)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	292		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,039,270	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,112,880	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 156,435	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	230,535		30
31	Accrued Taxes Payable (excluding real estate taxes)	7,204		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due Padres Corporation	469,099		36
37	Lines of Credit	1,025,047		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,888,320	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	307,831		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 307,831	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,196,151	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 916,729	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,112,880	$	48

***(See instructions.)**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,119,570	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,119,570	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(202,841)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (202,841)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 916,729	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,742,638	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,742,638	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	1,704	24
25	Interest and Other Investment Income***	1,532	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,236	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unspecified Income	291	28
28a	Grants Restricted Use	61,077	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 61,368	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,807,242	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,113,995	31
32	Health Care	2,742,177	32
33	General Administration	1,780,063	33
	B. Capital Expense		
34	Ownership	288,438	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	85,410	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,010,083	40
41	**Income before Income Taxes (line 30 minus line 40)****	(202,841)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (202,841)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,864	2,104	$ 64,165	$ 30.50	1
2	Assistant Director of Nursing	1,512	1,647	44,276	26.88	2
3	Registered Nurses	11,230	12,344	361,280	29.27	3
4	Licensed Practical Nurses	20,792	25,968	480,087	18.49	4
5	Nurse Aides & Orderlies	90,452	107,460	1,039,594	9.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,556	2,825	38,445	13.61	8
9	Activity Director	1,690	1,957	25,413	12.99	9
10	Activity Assistants	9,872	10,926	85,737	7.85	10
11	Social Service Workers	6,320	7,126	94,039	13.20	11
12	Dietician					12
13	Food Service Supervisor	5,945	6,913	90,846	13.14	13
14	Head Cook	6,303	6,859	65,769	9.59	14
15	Cook Helpers/Assistants	11,093	12,321	92,705	7.52	15
16	Dishwashers	11,887	12,742	83,972	6.59	16
17	Maintenance Workers	9,639	10,667	118,647	11.12	17
18	Housekeepers	7,956	8,596	58,994	6.86	18
19	Laundry	8,986	10,080	90,445	8.97	19
20	Administrator	1,996	2,280	122,707	53.82	20
21	Assistant Administrator	1,916	2,080	79,900	38.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,409	16,274	179,633	11.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,251	3,851	47,056	12.22	31
32	Other Health Care(specify)					32
33	Other(specify) Executive Director			42,654		33
34	TOTAL (lines 1 - 33)	229,669	265,020	$ 3,306,364 *	$ 12.48	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 9,638	line 1, col.3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant		24,713	line 10,col.3	38
39	Pharmacist Consultant		5,633	line 10,col.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,333	line 12,col.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 41,317		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,299	$ 104,614	line 10 col 3	50
51	Licensed Practical Nurses	2,455	85,920	line 10 col 3	51
52	Nurse Aides	2,770	51,251	line 10 col 3	52
53	TOTAL (lines 50 - 52)	7,524	$ 241,785		53

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Gilbert Torres	Administrator	0	$ 122,707
Cathy Soto	Assistant Administrator	0	79,900
Ann Alvarez	Executive Director	0	42,654
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 245,261

B. Administrative - Other

Description	Amount
Administrative Fees	$ 504,084
TOTAL (agree to Schedule V, line 17, col. 3)	$ 504,084
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Stone,Mcguire & Benjimen	Legal	$ 2,665
Harris Kessler	Legal	2,578
American National Bank	Banking Services	3,854
FPT & W	Audit Fees	6,000
D.L.M. Financial Advisory Services	Accounting Services	16,016
ADP	Payroll Processing	23,320
Health Data Services	Data Processing Accounts Rec	8,619
Accumed - Med Services Inc.	Security System Services	4,245
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 67,297

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 204,022
Unemployment Compensation Insurance	14,562
FICA Taxes	250,380
Employee Health Insurance	160,729
Employee Meals	311
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,471
Employee Performance Awards	1,984
TOTAL (agree to Schedule V, line 22, col.8)	$ 634,459

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,169
Health Care Worker Background Check	
(Indicate # of checks performed)	
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,169

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Staff Transportation Reimburesement	
Seminar Expense	
Refer to Attached Schedules	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Center Home for Hispanic Elderly # 0038893 Report Period Beginning: 07/01/01 Ending: 6/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Casa Central Senior Lunch Program

Supporting Schedule for Page 5
Line ,Other Adjustments

Month	Total Meal	Total Amount Invoiced	
1-Jul	532	1623	
1-Aug	510	1556	
1-Sep	419	1278	
1-Oct	532	1738	
1-Nov	471	1539	
1-Dec	446	1463	
2-Jan	577	1875	
2-Feb	504	1644	
2-Mar	440	1430	
2-Apr	532	1729	
2-May	500	1634	
2-Jun	477	1550	
Total	5940	19059	Total Adjustment to Raw Food Cost

Facility Name & ID Number Center Home for Hispanic Elderly **#** 0038893 **Report Period Beginning:** 07/01/01 **Ending:** 6/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network,**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,123** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,410**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **No**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Not Applicable**
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **FPT & W** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit is not complete.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

OPEN QUESTIONS: CENTER HOME COST REPORT FOR F/Y/E 6/30/02

1. MEALS ON WHEELS FOR ADULT DAY CARE? PAGE 2 Are there any outside services being provided by Center Home?
2. BANK HOLDING MORTGAGE ORIGINAL BALANCE INTEREST RATE INTEREST EXPENSE MATURITY DATE
3.AMERICAN NATIONAL BANK BEGIN BALANCE AVG INTEREST RATE MATURITY DATE
3, WASHINGTON SQUARE BANK ORIG LOAN AMT, ENDING BALANCE, INTEREST RATE , MATURITY DATE
4. QUESTIONS ABOUT CONTENT OF FOLLOWING ACCOUNTS:
2303,4181,4187,4210,4615,4650(TWO AMOUNTS),4710,5010,5030,5040 (TWO AMOUNTS)
5. The total Salaries per the general ledger are 3,306,364; the salaries reported by human resources are 3,450,918
a difference of 144,55 Please reconcile the difference.